CHAPTER VI

UTILIZATION REVIEW AND CONTROL

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INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance Program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services by providers and by recipients. These reviews are mandated by Title 42 Code of Federal Regulations, Parts 455 and 456. The Department of Medical Assistance Services (DMAS) conducts periodic utilization reviews on all programs. In addition, DMAS conducts compliance reviews on providers that are found to provide services in excess of established norms, or by referrals and complaints from agencies or individuals.

Participating Medicaid providers are responsible for ensuring that requirements for services rendered are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request. This chapter provides information on utilization review and control requirement procedures conducted by DMAS.

COMPLIANCE REVIEWS

The Department of Medical Assistance Services routinely conducts compliance reviews to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455. Providers and recipients are identified for review by systems generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.

To ensure a thorough and fair review, trained professionals employed by DMAS review all cases using available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

Statistical sampling and extrapolation may be used in a review. The Department may use a random sample of paid claims for the audit period to calculate any excess payment. When a statistical sample is used, the amount of invalid payments in the audit sample are compared to the total invalid payments for the same time period, and the total amount of the overpayment is estimated from this sample. Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate

documentation to support their claims, or billed for medically unnecessary services. In addition, due to the provision of poor quality services or of any of the above problems, Medicaid may restrict or terminate the provider's participation in the program.

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred recipients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See "Exhibits" at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate recipients on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, fax, or in writing. A toll-free helpline is available for callers outside the Richmond area. An answering machine receives after-hours referrals. Written referrals should be mailed to:

Supervisor, Recipient Monitoring Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-6548
CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the recipient and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

INTENSIVE REHABILITATION AND COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY (CORF) SERVICES

Utilization Review

Utilization controls are important to ensure high quality care as well as the appropriate provision of services. Many of the review and control requirements respond to federal requirements. Rehabilitation providers must comply with all of the requirements in order to receive Medicaid reimbursement for the services provided. *Virginia Administrative Code*, 12 VAC 30 Chapter 60, § 120)

Admission Review

DMAS requires utilization review of intensive rehabilitative services for all Medicaid admissions by the admitting rehabilitation provider. Medicaid requires 100 percent utilization review of Medicaid recipients in an intensive rehabilitative setting. The intensive rehabilitation provider must have an annual utilization review plan approved by the Office of Health Facilities Regulation, Virginia Department of Health, or the appropriate licensing agency in the state in which the institution is licensed, reflecting 100 percent review of Medicaid recipients. DMAS staff will review the functions associated with approved hospital utilization review plans for compliance with the *Code of Federal Regulations*, 42 CFR §§ 456.101-456.145. The CFR may be referenced for additional regulations.

The facility's utilization review coordinator must approve the medical necessity, within one working day of admission. In the event of an intervening Saturday, Sunday, or holiday, a review must be performed the next working day and must be reflected in the utilization review plan as well as the recipient's medical record.

Utilization Review Plan

Following admission, an initial stay review date must be assigned within the 50th percentile of norms approved by the Utilization Review Committee except in circumstances properly documented in the progress notes and reflected on the utilization review sheets. Continued or extended stay review must be assigned prior to or on the date assigned for the initial stay. If the facility's Utilization Review Committee believes that an intensive continued stay is not medically necessary, it may review the case at any time.

If the admission or continued stay is found to be medically unnecessary, the attending physician must be notified and be allowed to present additional information. If the hospital physician advisor continues to find the admission or continued stay unnecessary, a notice of adverse decision must be made within one working day after the admission or continued stay is denied. Copies of this decision must be sent by the Utilization Review Committee's designated agent to the hospital administrator, attending physician, recipient or the recipient's authorized representative, and DMAS. DMAS notification must be sent to:

Supervisor, Facility and Home-Based Services Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Medical Care Evaluation Studies (MCEs)

As part of their utilization review plan, hospitals must have one medical care evaluation study in process and one completed study each calendar year.

Utilization Review Plan (CORFs)

The Comprehensive Outpatient Rehabilitation Facilities (CORF) must have in effect a written utilization review plan implemented at least quarterly to assess the necessity of services and to promote the most efficient use of services provided by the facility. The Utilization Review Committee, consisting of physicians and professionals representing each of the services provided by the facility, a committee of this group, or a group of similar composition comprised of professional personnel not associated with the facility, must carry out the utilization review plan. Refer to 42 CFR § 485.66 for additional regulations.

The utilization review plan must contain written procedures for evaluating all of the following:

- Admissions, continued care, and discharges using, at a minimum, the criteria established in the recipient care policies of the facility;
- The applicability of the plan of care/treatment plan to established goals; and
- The adequacy of clinical records to assess the quality of services provided and to determine whether the facility's policies and clinical practices are compatible, and to promote the appropriate and efficient utilization of services.

Rehabilitation providers must provide the same rehabilitation services to the Medicaid recipient as provided to the general population, in accordance with the established Medicaid reimbursement rate. As per the provider agreement, a Medicaid-enrolled provider must accept Medicaid payment as payment in full.

Services not specifically documented in the recipient's medical record as having been rendered will be deemed not to have been rendered, and no reimbursement will be provided. All rehabilitative services shall be provided in accordance with guidelines found in the *Virginia Administrative Code* and the Virginia Medicaid *Rehabilitation Manual*.

DOCUMENTATION REQUIREMENTS: INTENSIVE REHABILITATION AND CORF SERVICES

<u>Discipline Documentation in the Recipient Medical Record</u>

Physician

The physician admission rehabilitation evaluation must include, but is not limited to, all of the following:

- The prognosis, clinical signs and symptoms necessitating admission;
- A description of prior treatment and, if applicable, attempts to rehabilitate the recipient in a less intensive setting;
- A chronological picture of the recipient’s clinical course and progress in treatment (history and physical, progress notes, and discharge summary completed within 30 days of the recipient’s discharge);

- The written initial certification statement of the need for intensive rehabilitation; and
- The identification of a discharge plan/disposition.

The physician plan of care/treatment plan must be written to include orders for medications, rehabilitative therapies (including the frequency and duration of services), treatments, diet, and other required services such as psychology, social work, therapeutic recreation, etc.

The physician plan of care/treatment plan must be specifically designed for the recipient and must be reviewed and rewritten at least every 60 days.

The physician is responsible for admission and discharge orders (if verbal orders are given, written orders must be signed and dated within three calendar days). Any discipline that discontinues therapy treatment prior to the discharge of the recipient must have a physician order to discontinue services.

The physician progress notes must be written at least monthly (every 30 days) and must include, but are not limited to:

- Changes in the recipient's condition;
- Recipient response to treatment;
- Renewal of recertification statement of the continuing need for intensive rehabilitation written at least every 60 days; and
- Discharge disposition statement.

DMAS has developed three (3) new forms that are required for physician use. The new forms, effective for dates of service on or after May 1, 2002, are as follows: DMAS Intensive Rehabilitation Physician Plan of Care Review (DMAS-126), DMAS Intensive Rehabilitation Admission Certification (DMAS-127), and DMAS Intensive Rehabilitation 60-Day Recertification (DMAS-128).

These three forms have been developed to assure physician compliance with documentation requirements for the physician orders and certification/recertification statements. See the "Exhibits" section at the end of this chapter for copies of these three required forms.

Review of the 60-day plan of care is defined as reviewing all physician orders pertaining to medications, rehabilitative therapies, treatments, diet, and other required services such as psychology, social work, therapeutic recreation, etc. The plan of care review of the physician orders provides the physician with an opportunity to review the patient's status over the past two months, rather than a day-to-day review. The physician must determine in writing on the DMAS-126 form, what services need to be continued, added, changed, or deleted, based on the individual's needs. The required form (DMAS-126) for this purpose must be fully completed, signed and dated by the physician, and placed in the physician order section of the medical record.

All physician documentation must be signed and dated by the physician. A required physician signature for DMAS purposes may include signatures, written initials, computer entry, or rubber stamp initialed by the physician. These methods only apply to DMAS requirements. If a physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must provide administration with a signed statement to the effect that he or she is the only person who will use the rubber stamp. The physician must initial and completely date all rubber-stamped signatures at the time it is used.

Rehabilitation Nursing

A registered nurse (RN), or a licensed practical nurse (LPN) under the supervision of a registered nurse, is responsible for and must complete, sign, title and fully date, all of the following documentation:

- An admission evaluation and initiation of the plan of care/treatment plan with measurable recipient goals written within 24 hours of admission;
- Nursing notes, written at least weekly, which reflect the care provided, recipient/family education, changes in the recipient's condition, the recipient's response to treatment; and revision of the recipient goals as needed; and
- Medications and treatments administered and charted as ordered by the physician.

A registered nurse (RN) is responsible for and must complete, sign, title, and fully date, all of the following documentation:

- A review of the recipient plan of care/treatment plan, as needed, but at least every two weeks; and
- A review of medications, at least monthly, to include identification of medications that may be discontinued or altered, and validation of the proper administration of ordered medications.

The recipient's condition must require, in addition to any acute care nursing services, the nursing knowledge and skills necessary to identify nursing needs and treat individuals whose conditions are characterized by altered cognitive and functional ability. The need for these rehabilitative nursing services is determined by deficits documented in the rehabilitative nursing admission assessment. This assessment and a physician-approved plan of care/treatment plan are developed by a registered nurse (or LPN under the supervision of the RN) experienced in rehabilitation.

The registered nurse (or LPN under the supervision of the RN) develops the plan of care/treatment plan by documenting individualized, measurable, recipient-oriented goals with time frames for achievement and the nursing interventions necessary to assist the recipient in achieving the goals. The nursing plan of care/treatment plan must reflect the expectation of significant improvement in the identified deficits.

Recipient response to nursing interventions and any resultant changes in the recipient goals must be documented in the weekly progress notes by nurses responsible for recipient care. The registered nurse must review recipient response to the nursing plan of care/treatment plan at least every two weeks and document any necessary modifications to the plan of care/treatment plan.

Rehabilitative Therapies (PT, OT, SLP, Cognitive, Therapeutic Recreation)

All rehabilitation services must be ordered by a physician.

Each therapist's admission evaluation must be completed by a registered or licensed therapist within seven (7) days of admission and must include, but is not limited to:

- Diagnosis of the recipient;
- History of any previous rehabilitation services; and
- Prior/current functional status.

A plan of care/treatment plan specifically designed for the recipient must be established and must include, but is not limited to:

- Recipient measurable goals;
- Time frames for goal achievement;
- Interventions (modalities/treatments);
- Frequency and duration of the therapies; and
- Discharge disposition/plan.

Progress notes must be written at least every two weeks and must include, but are not limited to:

- Frequency and duration of the therapies;
- Recipient response to treatment; and
- Review of the plan of care/treatment plan.

Psychologist

All psychology services must be ordered by a physician prior to implementation.

An admission evaluation must be written by a licensed psychologist or a licensed clinical social worker within seven (7) days of admission and must include, but is not limited to:

- History;
- Diagnosis; and
- Identified needs/problems.

A plan of care/treatment plan specifically designed for the recipient must be established, reviewed/revised every two weeks and must include, but is not limited to:

- Individualized, measurable recipient-oriented goals;
- Time frames for goal achievement;

- Interventions/approaches used;
- Frequency and duration of services offered; and
- Discharge disposition/plan.

Progress notes must be written at least every two weeks and must include, but are not limited to:

- Frequency and duration of the services;
- Recipient response to treatment; and
- Review of the plan of care/treatment plan.

Social Worker

All social work services must be ordered by a physician prior to implementation.

An admission evaluation must be written by the social worker within seven (7) days of admission and must include, but is not limited to:

- Social history;
- Diagnosis; and
- Identified needs/problems.

A plan of care/treatment plan specifically designed for the recipient must be established and must include, but is not limited to:

- Individualized, measurable recipient-oriented goals;
- Time frames for goal achievement;
- Interventions/approaches used;
- Frequency and duration of services offered; and
- Discharge disposition/plan.

Progress notes must be written at least every two weeks and must include, but are not limited to:

- Frequency and duration of services offered;
- Recipient response to treatment; and
- Review of the plan of care/treatment plan.

Discharge planning is an integral part of the recipient's plan of care/treatment plan developed by the team and coordinated by the social worker. The discharge plan must be addressed during the admission evaluation and must be reviewed/revised relative to the recipient's and family's response to the rehabilitation program.

Interdisciplinary Team

The interdisciplinary (ID) team must prepare written documentation of the ID plan of care/treatment plan within seven (7) days of admission.

Documentation must include, but is not limited to:

- Needs of the recipient;
- Individualized, measurable recipient oriented goals;
- Approaches to be used to meet the goals;
- The discipline responsible for the goals; and
- Time frames for goal achievement.

Included in the interdisciplinary plan of care/treatment plan must be a discharge plan. This plan must facilitate an appropriate discharge and must include, but is not limited to:

- Anticipated improvements in functional levels;
- Time frames necessary to meet the goals;
- Recipient's discharge destination;
- Any modifications and alterations necessary at the recipient's home for discharge; and
- Alternative discharge plans if the initial plan is not feasible.

Team conferences (identifying those persons attending the meeting), must be held every two weeks to review the plan of care/treatment plan. Documentation must include approaches and progress made toward meeting established interdisciplinary goals, revisions/changes to goals, and the discharge plan.

Since the effectiveness of an intensive rehabilitation program depends on the continuing coordination of all the disciplines involved in the recipient's rehabilitation, team conferences held at least every two weeks are required in order to assess and document the recipient's progress as well as any problems impeding progress. The team will consider possible resolutions to the identified problems, reassess the continuing validity of the rehabilitation goals established at the time of the initial evaluation, reassess the need for any adjustment in these goals or in the prescribed treatment program, and re-evaluate discharge plans. Documentation must demonstrate a coordinated team approach. A review by the various team members of each others' progress notes does not constitute a team conference. A summary of the conference, noting the team members present, must be recorded in the clinical record at least every two weeks.

General Documentation Requirements

For each recipient, there must be a written plan of care/treatment plan established and periodically reviewed and signed by a physician. Services not specifically documented in the recipient's record as having been rendered will be deemed not to have been rendered, and any inappropriate payment may be recovered by DMAS. Each entry in the medical record must be completely signed and dated by the provider of treatment.

The medical record must include all of the following, but is not limited to:

- Diagnosis, current medical findings, including functional status, and the clinical signs and symptoms of the recipient's condition, including the diagnosis justifying admission, and documentation of the extent to which the recipient is aware of the diagnosis and prognosis;

- An accurate and complete chronological picture of the recipient's clinical course and treatments, including any prior rehabilitation treatment. If appropriate, the summary of treatment furnished and the results achieved during previous periods of rehabilitation services or institutionalization must be provided;
- Plans of care/treatment plans by the interdisciplinary team and each involved discipline, specifically designed for the recipient to include realistic, individualized, measurable, recipient-oriented goals with time frames for achievement;
- Physician orders and plan of care/treatment plan prior to the provision of services;
- Documentation of all treatment rendered to the recipient with specific attention to the frequency, duration, interventions, response, and progress toward established goals. All entries must be fully signed and fully dated by the provider of the treatment (include the full name and title);
- Documentation of changes in the recipient's condition and changes in the plans of care/treatment plans (team and/or individual discipline);
- Documentation of team conferences, including the names of all attending;
- Discharge plans (see below); and
- Discharge summaries describing functional outcome, follow-up plans, and discharge disposition. The discharge summaries must be completed within 30 days of the recipient's discharge.

Discharge Planning

Discharge planning must be an integral part of the overall plan of care/treatment plan developed at the time of admission to the program. The plan shall identify the anticipated improvements in functional abilities and the probable discharge destination. The recipient, unless unable to do so, or the responsible party, shall participate in the discharge planning. The discharge plan must demonstrate that adequate arrangements/services are made to meet the recipient's needs in the new environment. Documentation concerning changes in the discharge plan as determined by the response to treatment, shall be entered into the record at least every two weeks as a part of the team conference, but more often if the recipient's situation warrants.

In addition, each discipline must promptly prepare a discharge summary within 30 days after a recipient's discharge. The summary must document the recipient's progress and identify initial treatment goals that were and were not met. Recommendations for follow-up care must also be included.

DOCUMENTATION REQUIREMENTS: OUTPATIENT REHABILITATION SERVICES

Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services

The recipient's medical record must contain sufficient documentation to clearly identify the recipient and justify the need for services. Each discipline, physical therapy, occupational therapy, and speech-language pathology services must adhere to the documentation requirements.

The documentation in the recipient's medical record must include the all of the following, but is not limited to:

Physician

A physician's order is required prior to the provision of any service.

If a specialist admits the recipient to rehabilitation, the MEDALLION PCP must have made the referral to the specialist. The specialist must maintain documentation of coordination of services with the MEDALLION PCP.

Physician orders must include all of the following, but are not limited to:

- A physician order for the evaluation/assessment that identifies the specific therapy(s) ordered, frequency and duration of services, and modalities;
- A physician order for treatment that identifies the therapy, individualized, measurable, recipient-oriented goals, modality/treatment, frequency, and duration; and
- Each physician's entry into the record must be legibly signed, titled, and fully dated by the physician making the entry.

A separate physician order (e.g., script, prescription) for treatment is not necessary if all required components of a physician order are included in the physician's signed plan of care/treatment plan prepared by the registered/licensed therapist.

The physician is responsible for admission and discharge orders (if verbal orders are given, written orders must be signed and dated within three calendar days). Any discipline that discontinues therapy treatment prior to the discharge of the recipient must have a physician order to discontinue services.

Physician assessment must include all of the following, but is not limited to:

- Diagnosis;
- Clinical signs and symptoms;
- Functional status;
- Relevant history; and

- Reason for referral.

A copy of the physician's office visit note may substitute for a physician assessment if the note contains all of the necessary components as identified in this section of the manual under the physician and therapist assessment sections.

Therapist

Therapist assessment must include all of the following, but is not limited to:

- Medical diagnosis;
- Functional status;
- Current functional status (strengths and deficits);
- Indication for justification of therapeutic interventions;
- Summary of previous rehabilitative treatment and results; and
- Extent to which the recipient/responsible party is aware of the diagnosis and prognosis.

When ordered by a physician, an evaluation or re-evaluation must be completed by a therapist when a recipient is admitted to a service, when there is significant change in a recipient's condition, or when a recipient is readmitted to a service.

Plan of Care/Treatment Plan

The plan of care/treatment plan must be specifically designed for the recipient by the physician after any needed consultation with the therapist(s) *prior to the implementation of services*. The initial plan of care/treatment plan may be prepared and signed by the therapist and then sent to the physician for signature. The plan of care/treatment plan must be reviewed/renewed by the therapist and the physician with modifications determined by the recipient's response to therapy every 60 days or annually depending on the recipient sub-group classification (refer to Chapter IV).

Any initial plan of care/treatment plan or periodic renewal written by the qualified therapist must be signed and dated by the physician within 21 days of implementation of the plan. If a physician signature is not obtained within 21 days of the implementation of the plan of care, reimbursement will not be made for that plan of care until the date of the physician signature. Reimbursement will not be made if, at the time of the physician signature, the plan of care valid time frame has expired. Services provided without a physician's dated signature or incomplete physician's order, will not be reimbursed.

The plan of care/treatment plan must include all of the following, but is not limited to:

- Individualized, measurable, recipient-oriented goals (long-term and short-term) which describe the anticipated level of functional improvement;
- Time frames for goal achievement;
- Therapeutic interventions/treatments to be utilized by the therapist;
- Interventions/treatments to be carried out by the recipient or responsible party

(family member/caregiver) under direction of the therapist; and
- Identification of a discharge plan.

Discharge Planning

The discharge plan is developed as an integral part of the initial plan of care/treatment plan and must include all of the following, but is not limited to:

- The recipient's anticipated functional status at discharge;
- The recipient's anticipated discharge disposition;
- The recipient's or responsible party's participation in discharge planning; and
- The changes in the plan as determined by the recipient's response to therapy.

Verification of Services/Progress Notes

Progress notes must be an accurate and complete chronological picture of the recipient's treatments and clinical course. Documentation must include all of the following, but is not limited to:

- Dated documentation for each individual treatment session (visit);
- Modality/treatment/activity utilized;
- Recipient response to therapy relative to established goals;
- Changes in functional status;
- Changes in recipient condition;
- Recommendations for continued treatment relative to established goals;
- Recommendations for continued treatment relative to modifications to the plan of care/treatment plan; and
- Identification of the therapist providing the treatment, including the full name and title, and signature date.

Flow sheets/treatment logs may serve as data collection methods to document each individual therapy visit.

Discharge Summary

The discharge summary must be completed upon discharge and must include all of the following, but is not limited to:

- The reason for discharge;
- The recipient's functional status at discharge compared to admission status;
- The recipient's status relative to established goals met or not met;
- The recommendations for any follow-up care;
- The recipient's discharge destination; and
- The qualified therapist who developed the plan of care/treatment plan, must fully sign, title, and date the discharge summary.

MEDICAL RECORDS AND RECORD RETENTION

The facility or agency must recognize the confidentiality of recipient medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern medical record use and removal and the conditions for the release of information. The recipient's written consent is required for the release of information not authorized by law. Current recipient medical records and those of discharged recipients must be completed promptly. All clinical information pertaining to a recipient must be centralized in the recipient's clinical/medical record.
Records of rehabilitative services must be retained for not less than five years after the date of discharge. Records must be indexed at least according to the name of the recipient to facilitate the acquisition of statistical medical information and the retrieval of records for research or administrative action. The provider must maintain adequate facilities and equipment, conveniently located, to provide efficient processing of the clinical records (reviewing, indexing, filing, and prompt retrieval). Refer to 42 CFR 405.1722 for additional regulations.

The facility or agency must maintain medical records on all recipients in accordance with accepted professional standards and practice. The records must be completely and accurately documented, readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information.

All rehabilitative medical record entries must be fully signed and dated (month, day, and year) including the title (professional designation) of the author. A required physician signature for DMAS purposes may include signatures, computer entry, or rubber stamped signature initialed by the physician. These methods only apply to DMAS requirements. For more complete information, refer to the Medicaid *Physician Manual*. If a physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must provide the provider's administration with a signed statement to the effect that he or she is the only person who has the stamp and he or she is the only person who will use it. The physician must initial and completely date all rubber-stamped signatures at the time the rubber stamp is used.

See "EXHIBITS" at the end of this chapter for a summary of DMAS required documentation for outpatient rehabilitation services.

DMAS UTILIZATION REVIEW RESPONSIBILITIES OF INTENSIVE AND OUTPATIENT REHABILITATION

Utilization controls are important to ensure quality of care as well as the appropriate provision of services and the medical necessity for services. Many of the review and control requirements respond to Federal and State regulations; all participating providers must comply with all of the requirements.

The Department of Medical Assistance Services (DMAS) must provide for the continuing review and evaluation of the care and services covered by DMAS. This includes the review of the utilization of services rendered by providers to recipients.

Medical records of recipients currently receiving rehabilitation as well as a sample of closed medical records may be reviewed. DMAS may also conduct an on-site investigation as follow-up to any complaints received.

Periodic, unannounced, utilization review on-site visits or desk reviews will be made to each rehabilitation provider to review medical records and conduct an overall review of the provision of services with respect to all of the following:

- The comprehensive care being provided;
- The adequacy of the services available to meet the current health needs and to promote the maximum physical and emotional well-being of each recipient for the scope of services offered;
- The necessity and desirability of the continued services;
- The feasibility of meeting the recipient's rehabilitation needs at an alternate level of care; and
- For verification of agency/provider adherence to DMAS requirements in accordance with federal and state regulations.

Upon completion of an on-site review, the utilization review analyst(s) will meet with staff members as selected by the provider for an exit conference. The exit conference will provide an overview of the findings from the review. A report will be written detailing the findings of the analyst(s) during the utilization review. Based on the review team's report and recommendations, DMAS may take any corrective action necessary regarding retraction of payment. Actions taken and the level of management involved will be based on the severity of the cited deficiencies regarding adequacy of services and utilization control regulations.

If DMAS requests corrective action plans, the rehabilitation provider must submit the plan, within 30 days of the receipt of notice, to the utilization review analyst(s) who conducted the review. Subsequent visits/desk reviews may be made for the purpose of follow-up of deficiencies or problems, complaint investigations, or to provide technical assistance.

Note: Consideration by the DMAS utilization review analyst of the need for continued care does not replace the function of the provider's Utilization Review Committee for intensive rehabilitative services.

Reimbursement Requirements

Rehabilitative services that fail to meet DMAS criteria are not reimbursable. Such non-reimbursable services will be denied at the time of the preauthorization request or payment retracted at the time of the utilization review activities.

Intensive Rehabilitation

DMAS criteria for reimbursement of intensive rehabilitation are found throughout the provider manual and include all of the following, but are not limited to:

- The recipient meets the InterQual admission/concurrent criteria for reimbursement;
- A physician's admission order, signed and dated by the physician, prior to the provision of therapies/services;
- A plan of care/treatment plan prior to the provision of therapies/services including the physician admission assessment;
- Review and restatement of the physician order and plan of care/treatment plan (DMAS-126) every 60 days;
- Evidence of written physician admission certification statement (DMAS-127) and 60 day recertification statement (DMAS-128);
- Evidence of therapist admission assessment;
- The therapist plan of care/treatment plan with goals reviewed every two weeks;
- Documentation of significant progress toward recipient goals within a reasonable period of time;
- Evidence of physician and therapy discipline progress notes for each therapy visit;
- Reflecting recipient progress of functional status evidence of an interdisciplinary team approach, reviewed every two weeks;
- Documentation of appropriate and timely discharge planning; and
- Evidence of documentation for the services rendered and/or billed.

DMAS has developed three (3) new forms that are required for physician use. The new forms, effective for dates of service on or after May 1, 2002, are as follows: DMAS Intensive Rehabilitation Physician Plan of Care Review (DMAS-126), DMAS Intensive Rehabilitation Admission Certification (DMAS-127), and DMAS Intensive Rehabilitation 60-Day Recertification (DMAS-128).

These three forms have been developed to assure physician compliance with documentation requirements for the physician orders and certification/recertification statements. See the "Exhibits" section at the end of this chapter for copies of these three required forms.

Review of the 60-day plan of care is defined as reviewing all physician orders pertaining to medications, rehabilitative therapies, treatments, diet, and other required services such as psychology, social work, therapeutic recreation, etc. The plan of care review of the physician orders provides the physician with an opportunity to review the patient's status over the past two months, rather than a day-to-day review. The physician must determine in writing on the DMAS-126 form, what services need to be continued, added, changed, or deleted, based on the individual's needs. The required form (DMAS-126) for this purpose must be fully completed, signed and dated by the physician, and placed in the physician order section of the medical record.

<u>Outpatient Rehabilitation</u>

DMAS criteria for reimbursement of general outpatient rehabilitation are found throughout the provider manual and include all of the following, but are not limited to:

- A physician initial order, signed and dated by the physician prior to the provision

of therapies;
- A plan of care/treatment plan prior to the provision of therapies;
- The plan of care/treatment plan signed and dated by the physician within 21 days of the implementation of the plan of care/treatment plan;
- Review and renewal of the physician order and plan of care/treatment plan every 60 days for acute conditions requiring services for less than 12 months;
- Review and renewal of the physician order and plan of care/treatment plan annually for non-acute, long-term conditions requiring services for greater than 12 months. In school settings, the plan of care/treatment plan shall cover outpatient rehabilitative services provided during the school year;
- Evidence of the therapist admission assessment;
- The therapist plan of care/treatment plan with goals reviewed based on acute or non-acute condition;
- Documentation of significant progress toward the recipient goals within a reasonable period of time;
- Evidence of therapy discipline progress notes for each therapy visit;
- Evidence of documentation for services rendered and/or billed;
- Provider program-mandated evaluations or re-evaluations will not be reimbursed; and
- Documentation of the appropriate and timely discharge planning.

PROVIDER APPEAL PROCESS: UTILIZATION REVIEW DENIAL OF REIMBURSEMENT

Payment to the rehabilitation provider may be retracted when the provider has failed to comply with established federal and state regulations or policy guidelines.

The rehabilitation provider has the right to request reconsideration of retractions. The request for reconsideration and all supporting documentation, must be submitted within 30 days of written notification to:

Supervisor, Facility and Home Based Services Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

DMAS will review the documentation submitted and provide the rehabilitation provider with a written response to the request for reconsideration. If the retraction is upheld, the provider has the right to appeal the reconsideration decision by requesting an informal appeal within 30 days of the written notification of the reconsideration decision. The provider's request should include all information to as to why the retraction should not be made. The notice of appeal and supporting documentation shall be sent to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If the retraction is upheld, the provider has the right to appeal the informal appeal decision by requesting a formal appeal within 30 days of the written notification of the informal appeal decision. The notice of appeal and supporting documentation shall be sent to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

RECIPIENT APPEALS

If the denied service has not been provided to the recipient, the denial may be appealed only by the recipient or his or her legally appointed representative. Recipient appeals must be submitted within 30 days of the receipt of the denial of written notification to:

Director, Division of Appeals
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

Since payment of claims is made from both State and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or State court. The Program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading and adhering to applicable State and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Provider Review Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 E. Main Street, 5th Floor
Richmond, Virginia 23219

Recipient Fraud

Allegations about fraud or abuse by recipients are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card sharing and prescription forgeries.

If it is determined that benefits to which the individual was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit
Program Integrity Section
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

EXHIBITS

TABLE OF CONTENTS

MEDICAID-REQUIRED DOCUMENTATION FOR OUTPATIENT REHABILITATION

DISCIPLINE	ASSESSMENT	CARE PLAN	PROGRESS NOTES	OTHER
Physician	To include: Dx, Hx, current medical findings, clinical S & S, needs, deficits	Written, signed and dated Review every 60 days or annually with recertification of needs and estimated discharge		Orders to include: -Discipline -Specific procedures -Modality -Frequency -Duration
Physical Therapy	To include: Dx, Hx, current medical findings, clinical S & S, needs, deficits	Written, signed and dated and include short term and long term goals Review every 60 days or annually	Written for each visit Include patient response to treatment	Document patient/ responsible person awareness of diagnosis and prognosis
Occupational Therapy	To include: Dx, Hx, current medical findings, clinical S & S, needs, deficits	Written, signed and dated and include short term and long term goals Review every 60 days or annually	Written for each visit Include patient response to treatment	Document patient/ responsible person awareness of diagnosis and prognosis
Speech/ Language Pathology	To include: Dx, Hx, current medical findings, clinical S & S, needs, deficits	Written, signed and dated and include short term and long term goals Review every 60 days or annually	Written for each visit Include patient response to treatment	Document patient/ responsible person awareness of diagnosis and prognosis

CARE PLAN TO INCLUDE:

- Plan of treatment specific to needs identified in assessment.
- Measurable goals and time frame for meeting goals.
- Anticipated improvement in functional ability.
- Discharge plan and estimated discharge date.
- Any changes noted in writing, signed by physician and appropriate therapist.
- Physician's signature and date must be within 21 days of the renewal/modification.

PROGRESS NOTES TO INCLUDE:

- Treatment rendered
- Frequency
- Modality/Procedure/Activity
- Progress/Response
- Change in condition
- Date, Signature* and Title of provider(s). (*The therapist must *SIGN*, no stamps may be used.)

DOCUMENTATION GOALS:

- Specific
- Measurable
- Realistic
- Include time frames for achievement

Department Of Medical Assistance Services (DMAS)
Intensive Rehabilitation Physician Plan of Care Review

(Instructions for the completion of this form are located on the reverse side)

Per 42 CFR 456.80, the physician plan of care must be reviewed at least every 60 days, to include orders for medications, rehabilitative therapies, treatments, diet, and other required services such as psychology, social work, therapeutic recreation, etc.

NOTE: Please indicate if additional orders will be attached to this form by marking the appropriate box.

I. Patient's Name: _____

II. Medications: supplemental order sheet for medications attached

III. Rehabilitative Therapies:

___ P.T.
___ O.T.
___ SLP
___ Cognitive Rehab

IV. Treatments: supplemental order sheet for treatments attached

V. Diet:

VI. Other Services:

___ Psychology
___ Social Work
___ Therapeutic Recreation

VII. I certify that the above plan of care orders have been reviewed and medically necessary for this patient.

Physician Signature (month/day/year)

Instructions for Completion of the DMAS Intensive Rehabilitation Physician Plan of Care Review Form

I. Fill in patient's full (first and last name) name.

II. List all medications, including PRN medications. Must include name of drug, dosage, route, frequency, and duration, as applicable.

III. For each therapy that continues to be medically necessary, indicate by placing a check mark (√) next to the appropriate therapy.

IV. List all specific medical treatments that continue to be medically necessary.

V. List the diet and any specific restrictions (i.e.: ADA diet, no salt, etc.)

VI. For any other services (i.e.: psychology, social work, or therapeutic recreation), indicate by placing a check mark (√) next to the appropriate service.

VII. The physician must fully sign and fully date (month/day/year) his/her signature. Only the physician can date his/her signature.

***This form serves as the instructions for completion of the 60-day physician review of the plan of care. The physician must complete this form to meet plan of care documentation requirements for the intensive rehabilitation program.**

NOTE: If any additional orders are attached to this form, the orders must be referenced on the review form by checking the appropriate box provided. Any additional orders must be maintained in the medical record along with this form.

Department Of Medical Assistance Services (DMAS)
Intensive Rehabilitation Admission Certification

(Instructions for the completion of this form are located on the reverse side)

ADMISSION CERTIFICATION STATEMENT

I. Certification Statement:

In accordance with 42 CFR 456.60, I certify that _____(patient's full name) meets the admission criteria for intensive rehabilitation services set forth in 12 VAC 30-60-120:

II. Criteria Determination:

(In order to meet intensive rehabilitation services criteria the recipient must require all the items listed below)

The rehabilitation program cannot be safely and adequately carried out in a less intensive setting; and

The interdisciplinary coordinated team approach is required; and

The recipient requires rehabilitation nursing services for patient/family education in addition to skilled nursing care; and

The recipient requires at least two of the four therapies:
(Check the appropriate boxes)

Physical Therapy services on a daily basis

Occupational Therapy services on a daily basis

Cognitive Therapy services on a daily basis

Speech-Language Pathology services on a daily basis

III. Physician Signature Required:

Physician Signature (month/day/year)

Instructions for Completion of the DMAS
Intensive Rehabilitation Certification Form

I. In accordance with 42 CFR 456.60, the physician must certify for each recipient that inpatient services in a hospital are needed. The certification must be made at the time of admission. The recipient's full name shall be entered in this section.

II. In order to meet intensive rehabilitation services criteria the recipient must require all the items listed. In the section that identifies the four (4) rehabilitation therapies please check the appropriate boxes.

III. The physician shall fully sign and fully date (month/day/year) his/her signature. Only the physician can date his/her signature.

***This form serves as the instructions for completion of the physician admission certification. The physician must complete this form to meet admission certification documentation requirements for the intensive rehabilitation program.**

Department Of Medical Assistance Services (DMAS)
Intensive Rehabilitation 60-Day Recertification

(Instructions for the completion of this form are located on the reverse side)

60-Day Recertification Statement

I. Recertification Statement:

In accordance with 42 CFR 456.60, I certify that _____(patient's full name) continues to be appropriate for inpatient rehabilitation services and shall meet the Medicaid intensive rehabilitation criteria for the next 60 days as set forth in 12 VAC 30-60-120. This recertification is based on my review of the individual's current medical record documentation.

II. Criteria Determination:

(In order to meet intensive rehabilitation services criteria the recipient must require all the items listed below)

The rehabilitation program cannot be safely and adequately carried out in a less intensive setting; and

The recipient is able to actively participate in the intensive rehabilitation treatment plan developed by the interdisciplinary team; and

The interdisciplinary coordinated team approach is required; and

The recipient requires rehabilitation nursing services for patient/family education in addition to skilled nursing care; and

The recipient requires at least two of the four therapies:
(Check the appropriate boxes)

Physical Therapy services on a daily basis

Occupational Therapy services on a daily basis

Cognitive Therapy services on a daily basis

Speech-Language Pathology services on a daily basis

III. Physician Signature Required:

_____

Physician Signature (month/day/year)

Instructions for Completion of the DMAS
Intensive Rehabilitation 60-Day Recertification Form

I. In accordance with 42 CFR 456.60, the physician must recertify for each recipient that inpatient services in a hospital are needed. The recertification must be made at least every 60 days after certification. The recipient's full name shall be entered in this space provided.

II. In order to meet intensive rehabilitation services criteria the recipient must require all the items listed. In the section that identifies the four (4) rehabilitation therapies check the appropriate boxes.

II. The physician shall fully sign and date (month/day/year) his/her signature. Only the physician can date his/her signature.

***This form serves as the instructions for completion of the physician 60-day recertification. The physician must complete this form to meet recertification documentation requirements for the intensive rehabilitation program.**